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ABSTRACT

Because hospitalization is often a frightening and traumatic experience for children and their families, a practicum designed a system of inservice training experiences for hospital personnel. These experiences were intended to enhance or develop skills that would assist them in addressing the needs and concerns of hospitalized children and their families. The practicum was conducted in a 286-bed, private acute care medical center. Issues addressed included needs and concerns of ill children, communication skills, separation anxiety, pain management, and preparation for procedures. Methods of presentation included written materials and clinical supervision. The plan was implemented within one hospital department as a prototype program. Results of the practicum indicated positive changes in staff behaviors and an increase in the level of staff comfort in working with pediatric patients. (Appendixes to the report include employee sample surveys concerning needed workshops addressing pediatric issues, current department practices, and staff level of comfort. A sample evaluation form is also included.) (Contains 14 references.) (Author/KC)

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Development of an Inservice Training Program for Health Care Professionals Working with Pediatric Patients to Increase Awareness of Needs and Concerns of Such Patients

by
Janiece A. Crovella
Cohort 45

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A Practicum Report Presented to the
Master's Program for Child and Youth Care Administrators
in Partial Fulfillment of the Requirements
for the degree of Master of Science

NOVA UNIVERSITY
1992

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AUTHORSHIP STATEMENT

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October 23, 1992
Date

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Signature of Student

Abstract

Development of an inservice training program for health care professionals working with pediatric patients to increase awareness of needs and concerns of such patients. Crovella, Janiece, 1992: Practicum Report, Nova University, Masters Program for Child Care Administrators. Descriptors: Health Care Professional/ Psychosocial/Communication/Coping/Cooperation/Interpersonal Relationships/Staff Development/Child/Hospitalized Children/ Pediatrics/Child Development.

The medical environment can be a frightening and traumatic experience for children and their families. There are sights and sounds foreign to both the child and the parent. Procedures and routines may be painful and necessitate separation from family. Interaction between the family and hospital personnel can make the difference in the medical experience being a positive event or an negative event. Lack of knowledge on the part of hospital personnel on possible issues of concern for pediatric patients and their families may contribute to possible trauma.

This practicum designed a system of inservices to provide hospital personnel with the opportunity to enhance or develop skills that would assist them in addressing the needs and concerns of hospitalized children and their families. Issues addressed included needs and concerns of ill children, communication skills, separation anxiety, pain management, preparation for procedures. Method of presentation included written materials and clinical supervision. The plan was implemented within one hospital department to act as prototype program.

Results of the practicum indicated positive changes in staff behaviors with pediatric patients and an increase in the level of staff comfort in working with pediatric patients. Appendices include employee sample surveys concerning needed workshops addressing pediatric issues, current department practices, staff level of comfort. Sample evaluation form is also included.

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Student's Name Janiece A. Crovella

Cohort 45 Date October 26, 1992

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Chapter 1

INTRODUCTION

The practicum setting is a 286 bed, private, religious affiliated, acute care medical center. The community served by the medical center represents a broad spectrum of social, economical, and ethnic backgrounds. A large section of the population served, approximately 40%, are non-English speaking, primarily Hispanic and Asian. The medical center provides a variety of patient services. Most notably is the cardiac diagnostic lab, one of the largest and busiest in the State.

Children who are treated at the medical center are seen usually in three areas, the pediatric unit, same day services unit, and the emergency room. The pediatric unit is licensed for 26 beds, accommodating patients ages 1 day to 14 years. Older patients are admitted to the unit upon physician's order. The average daily census of the unit is 8 to 10 patients. Average patient stay is 3 to 5 days. The diagnoses of the patients involve non-infectious conditions (asthma, diabetes, congenital defects), infectious conditions (measles, meningitis, hepatitis, upper respiratory), surgical cases (elective, emergency), and diagnostic procedures. The pediatric staff consists of 10 registered nurses, three assigned nurses aides, one child life specialist. The unit provides services to approximately 22 pediatricians.

Same Day Services is a ward-like unit for both adult and pediatric patients. The unit holds 12 post-operative beds, four

chaise recliners, four pre-operative beds, and one infant room. Breakdown of patient services are: 65% elective surgery, 20% heart catherizations, 10% radiology procedures, and 5% brochscotomies or other services. The average pediatric census is 10 to 12 patients. 90% of those patients receive elective surgery, 8% heart catherizations, and 1% radiology procedures. The unit is considered a admission/discharge center with average patient stay being 3 hours.

The emergency room is a twenty-two bed licensed facility. It consists of two labor/maternity rooms, two infant rooms, three trauma/cardiac sites, two bed fast-track area, and 15 other patient care beds. The emergency room serves an average of 1,000 pediatric patients a month.

The author is a non-medical member of the pediatric staff. Her educational background is in child development with specialized studies pertaining to the effects of disease and injury on children and families, therapeutic play, medical terminology, and related subjects. Responsibilities of the author include planning and implementing activities that enhance the coping skills of young patients, promoting continued growth and development, providing opportunities for expression of needs, concerns, and feelings while promoting understanding and mastery of the hospital experience. The author also acts as liaison for the patient, family, and staff to help provide continuity of care through the communication of information, normalization of the environment, and the continued parental role. Administrative duties involve

documentation of patient activities and interactions; recording unit census information; equipping and maintaining playroom; developing and implementing community programs; and ongoing program evaluation.

The author is primarily involved with inpatient pediatrics with a special interest in pediatric cardiology patients. Networking with other departments usually is limited to needs of the pediatric inpatient with the exception of pediatric cardiac patients in Same Day Services.

Chapter Two

STUDY OF THE PROBLEM

Problem Statement

The medical center did not have a systematic method that provides hospital personnel the opportunity to enhance or develop skills that would assist them in addressing the needs and concerns of hospitalized children and their families. The medical environment can be a frightening and traumatic experience. There are sights and sounds foreign to both the child and the family. Procedures and routines may be painful and necessitate separation from family. The difference between the medical experience being a positive event or a negative event is often the interaction between the family and the hospital personnel. It is with each encounter that trust and relationships are built. Possessing knowledge that is limited to the completion of one's job without recognition of other possible issues of concern for the patient is not serving the best interest of that patient or their family.

Documentation

A focus of concern in the medical center is providing high quality care to its' patients. In the medical center's general orientation information it is stated that "clients perceive high quality care as that which is delivered in a personal, prompt, courteous, convenient and professional manner. Customers [patients]

want competent care delivered by a staff who are knowledgeable and who are willing to provide information" (1992, p. 16). The emphasis here is that all employees are part of the process that provides care.

In interviews with supervisors in 5 departments in which children have the most contact -- emergency room, laboratory, radiology, pediatrics, and surgery, inservices within the department involving new or presently employed personnel, were limited to the function of their duties and/or the operation of department equipment. Possible psychosocial, behavioral, or emotional issues were not addressed.

A review of programs and inservices offered by the education department of the medical center found pediatric information limited to CPR courses, bioethic case studies, or televised video presentations. Content of the sessions usually pertained to disease or injury, treatment, and outcome. Participant's involvement was limited. Feedback was in the form of evaluation forms or short question/answer sheets to verify that the person did indeed attend, listen, or watch the session.

Early in 1992, a survey (See Appendix A) was conducted to assess what areas of information employees felt would benefit them in working with pediatric patients. Eight specific areas were listed with a ninth space for added suggestions. The employees were also asked to report any inservices, courses, or workshops they had attended that related to pediatric patients. Of the 100 surveys issued 46 were returned. A summary of the survey is found

in Table 1, for complete tabulation of results see Appendix B. The three issues selected by 60% or more of the employees were: psychological/emotional/behavioral preparation of children for medical procedures, needs and concerns of ill children, and the use of appropriate language/vocabulary/terminology with children. Only six respondents indicated that they had attended any courses or seminars related to working with children.

Table 1

Survey of Health Care Employees
Issues in Working with Pediatric Patients

Identified Issues	Number of Responses	Percentage (n=46)
Preparation of children for medical procedures. (Psychological/emotional/behavioral)	34	73%
Needs and concerns of ill children.	32	69%
Use of appropriate language/vocabulary/ terminology with children.	30	60%
Parental participation in the child's care/treatment.	25	54%
Coping styles of children.	22	47%

Analysis

Rising costs, limited resources, and competitive services within the medical field provide a challenge in addressing the issue of quality care. In working with the pediatric patient the person who may be defining the quality of the child's care is the parent or guardian. Their perception of the child's care determines their view of the institution. Acute care facilities, such as this medical center, serve a wide variety of patients including pediatric patients. Unlike a children's hospital where all services are geared with the pediatric patient in mind, an acute facility must integrate the child into its services. The question is when this integration takes place how prepared are those employees, who provide the service, to work with children?

The medical center's general orientation packet for new employees contains a chapter on customer relations. This is the term used to promote quality care. Components of the seven page chapter include employee attitudes, first impressions, telephone techniques, patient's rights, and guidelines for handling tense situations. Half a page is devoted to "understanding customer behavior". A parallel is drawn between an iceberg and customer behavior. Behavior being the tip of the iceberg and influencing factors of the behavior being that which is underneath the water. A list of those influencing factors are given: feelings, attitudes, values, perceptions, goals, needs, and motives. To accomplish understanding, the suggestions given are to observe

behavior, ask oneself what may be influencing the behavior, and say or do whatever may be done to meet the need. The suggestions may be very good but, there is no foundation of knowledge presented to the employee giving guidelines to possible issues patient's may experience or resources to aid the patient. There certainly is not a delineation made between adult patients and pediatric patients. The assumption is they are one in the same.

The employee survey demonstrated a lack of training on the part of health care professionals at the medical center. Their own reporting of workshops and courses related to children was almost non-existing.

The effects of hospitalization on children has been frequently addressed and examined. Two extensive reviews of literature on the subject was conducted by Vernon, Foley, Sipowicz, and Schulman (1965), and Thompson (1985). Over 500 papers were summarized and critiqued. The body of published works included experimental and quasi-experimental designs. They examined psychosocial interventions for emotional support, preparation for health care procedures, parental involvement, and play. A consistent factor in the psychosocial impact of hospitalization was developmental age. Generally, children aged 6 months to 4 years were seen to be at higher risk than children of school age (Thompson, 1985). Children at the younger age identify their experiences through their own limited physical surrounding. Their world revolves around their physical being and needs. If these needs are not met then emotional upset may be a result.

Children of school age are in a period of time where they are more logical and rational. It is during this age that children can accept the reason for illness and the treatment that follows. Children of this age focus on only one idea at a time and health knowledge may be of a general nature. Talking directly with the child about medical events and treatments is considered an appropriate approach (Stevens, 1989).

Hospitals are complex institutions with hundreds of trained professionals in a variety of fields. It is the combined efforts of those professionals that serves in the treatment of each patient. The result is that the patient has contact with numerous unknown persons, doing a variety of procedures from admitting paperwork to intricate procedures to environmental maintenance. Each specialized worker has their own agenda and understanding of what needs to be done. An adult can absorb these interactions with little or no upset but for a child the experience can be devastating. With the involvement of so many people in the care of patients, each with there own perspective and knowledge base, it is important to communicate and understand the concerns of children. Particularly, medical personnel need to know about working with different age groups, how to explain medical/surgical conditions and procedures, and how to assist a child in coping with and mastering the stresses of hospitalization (Petrillo & Sanger, 1980).

Parents often define the quality of care their child receives by their interaction with the medical staff. In a study by Knalf,

Breitmayer, Gallo, and Zoeller (1992) the relationship between family members and care providers was examined. Behaviors that promoted good working relationships and positive experiences were explored. The results of the study showed that parents valued and respected the expertise of care providers but desired to have the information communicated in a compassionate and respected manner. Parents held in high esteem care providers who valued the parental role and encouraged the continuation of that role within the medical environment. More importantly for parents was that the care provider could effectively interact with their child. These results were consistent with previous studies that identified basic skills needed by professionals who work with ill children.

The problem was that there was little training for medical personnel in child development, issues of hospitalized children, or related matters unless that was the core concern for the professional. Pediatric physicians and nurses lag in information that is vital to caring for the patient as a whole entity and not just a disease. Betz and Poster (1984) assessed the knowledge of pediatric nurses on the psychosocial development of children as affected by hospitalization and nursing care. The results determined that there was a large void in the nurses knowledge of the four stages of childhood development in dimensions of play development, time concept, medical preparation, and psychosocial/psychosexual growth. This lacking on pediatric staff was intensified with personnel in other disciplines.

Chapter 3

Anticipated Outcomes and Evaluation Instruments

The goal of this practicum was to create a systematic method that provided hospital personnel the opportunity to enhance or develop skills that would assist them in addressing the needs and concerns of hospitalized children and their families.

Due to the size of the institution the method created was to be a proto-type placed into operation in one department of the medical center.

The following objectives were projected for this practicum:

1. The staff members will demonstrate an enhanced ability and greater personal comfort in dealing with children during medical procedures. This will be illustrated by pre- and post-attitudinal surveys which will measure level of comfort in dealing with children during medical procedures, routine practices in specific patient situations and typical language used with patients. In addition, objective observation by the investigator will quantify other changes in behaviors and language usage by health care employees.

2. The majority of the staff will agree that the method chosen adequately meets their need for professional growth and development focussing on identification of potential areas of concern for children and appropriate language to use with children.

Staff response will be measured by an evaluation questionnaire. An employee survey, used in documentation portion

of this pracitcum, identified appropriate language and needs and concerns of children as issues employees felt would benefit them in working with children. Post-evaluation would show that the majority of staff members perceived the issues as having been adequately addressed.

Chapter 4

Solution Strategies

Existing Programs and Models

Over the last two decades increased attention has been placed on the role psychosocial factors play in the care and recovery of pediatric patients. The 1978 Task Force on Pediatric Education of the American Academy of Pediatrics recommended psychosocial issues be included as part of residency training (Rivara & Wasserman, 1984). On January 1, 1990, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) implemented a revised standard of care for hospitals that recognized that differences existed between the hospitalized pediatric patient and the adult patient. These differences require special services to meet the psychosocial, educational and medical needs of children. All hospitals in the United States are expected to meet these standards in order to receive accreditation as a viable medical institution.

Books have been written outlining programs to help address the needs and concerns of children during hospitalization. Azarnoff and Flegal (1975) wrote guidelines for developing a therapeutic play program in medical settings to help improve the emotional environment for children. Petrillo and Sanger (1980) presented preventive and interventive practices for medical professionals, of all disciplines, to help provide opportunities for continued growth, health, and maturity of hospitalized children. The book contains information on child growth and development, staff and

family interaction, assessment and management, play, preparation for procedures, and support systems. Thompson and Stanford (1981) outline the theory and practice of a child life program whose focus is the psychosocial, emotional care of hospitalized children and their families. A most comprehensive model of psychosocial care in hospitals is the Association for the Care of Children's Health (ACCH) Child Life Research Project completed in 1987 at Phoenix Children's Hospital (Gaynard, Wolfer, Goldberger, Thompson, Redburn, and Laidley, 1990). This model provides the integration of theory and practice in psychosocial care. Specific examples assist all professionals in understanding the psychosocial approach to working with children in hospitals.

These models are presented for the information and education of all medical professionals but are usually developed and implemented by professionals with a background in child development, psychology, or another related field. They do provide a framework for working with children and their families in an interdisciplinary environment that speaks to all aspects of the pediatric patient's care. The models recognize the need for personnel who are knowledgeable of the special needs and concerns of children and their families. They advocate not only for hiring experts in the field but also for the training of all medical professionals in awareness of these issues.

Programs have been developed, the target population being physicians and residents, that focus on improving communication skills, understanding continuity of care, and teaching psychosocial

issues. Ruane and Brody (1987) contend that continuity of care is a central issue in primary care of patients. They define continuity of care as including three elements ....cognitive, management, and relationships. Their premise is that residents need to have the cognitive elements of knowledge that gives them a sound medical knowledge and understanding of procedures to allow them to prescribe treatment, anticipate events, instruct the patient, and follow-up the course of action. Management skills are needed to understand the structure of the health care system to provide effective care. Relationship element is important as it reflects how the doctor-patient relationship is viewed. Each resident and physician needs to clearly define relationship expectations with patients to provide responsible care. The relationship expectations are concerned with medical treatment and follow-up care by the physician it does not include social or emotional issues of the patient.

An approach to improving pediatric residents' skills in communicating emotional-laden information to parents was studied by Wolraich, Albanese, Reiter-Thayer, and Barratt (1981). Residents participated in videotaped simulated family counseling sessions as part of their one-month mandatory rotation in developmental disabilities. Feedback was provided by the simulated parent and a pediatric faculty member. Results showed that resident's felt videotaping was an effective method in improving their communication skills in dealing with emotional-laden information. It provided immediate feedback on typical situations experienced by

the residents in interactions with parents.

Behavioral science literature shows that role-modeling is an effective means of teaching psychosocial skills. Rivara and Wasserman (1984) studied what effect the presence of a child psychiatrist on pediatric rounds would have on the number of psychosocial notes made by first year residents. The study itself showed the influence was negligible but when the attending physician whose interest was the entire span of biopsychosocial modalities, the number of psychosocial notes increased. This stressed the need for role models that combine both medical and psychosocial aspects of patient care.

Solution Strategies

In order to achieve the objective of providing medical personnel with a method for enhancing or developing skills that would assist them in addressing the needs and concerns of children and their families there were several components.

First component was to develop a tool to measure staff attitudes. Elements of the tool reflected the staff's routine practices and typical language used with children, and their comfort level in dealing with children during medical procedures. The pre-survey indicated existing staff practices and interactions with children. The post-survey indicated whether there was any change in staff practices in working with pediatric patients and in their level of comfort after participation in inservices addressing issues of working with this population. The question being whether

their knowledge had been enhanced to the degree that it reflected in their work. Assistance was sought from the education department of the medical center and from community resource persons in developing a valid tool. Observational study provided additional data as to staff behavior in interactions with children during medical procedures and an opportunity for clinical supervision.

A significant element of the process was the development of material to familiarize the staff with appropriate language to use with children and issues that concern children. The ACCH Child Life Research Project (Gaynard, et al, 1990) provided guidelines in both these areas that was relevant to this portion of the project. Specifically, material on preparation for procedures, health care play, separation issues. and communication with children and parents about health care experiences was valuable for this project. Other topics for inservice consideration were, coping styles of children, parental participation in the child's care/treatment, psyco-social issues, and basic child development information. Written material was to accompany oral presentation of each inservice topic. This material would reinforce and enhance information given orally.

Sessions were to be 30 to 45 minutes in length and include staff interactions in role-playing and problem solving in typical situations that arise in working with children. These interactions would provide the staff with the opportunity to observe each others behavior, discuss possible alternate behaviors, and practice those behaviors. The department's supervisor assisted in determining the

most appropriate time for presentation of material. Determination of cost depended on whether presentation of material was conducted on or off staff work time. The department's supervisor assisted in this decision.

Report of Action Taken

Several difficulties arose from the onset of the implementation process. The health care field, in general, is experiencing major financial revisions due to rising costs in medical care and services. Just prior to placing this system into action the medical center instituted new staffing policies to help enable the institution to function without personnel layoffs. This policy required mandatory flex time and paid-time-off days, early call offs, elimination of overtime, realignment of staffing in ratio to patient census, and re-organization of department personnel. The new staffing policy and budget constraints made an immediate impact on the implementation process.

First difficulty experienced was in obtaining assistance from the medical center's education department in developing tools for staff survey and observational study as outlined in the implementation plan (Appendix C). Samples of surveys and questionnaires were collected from the education department but due to staff limitation, assistance in formulation of the survey and questionnaire was provided by a community resource person contacted by the investigator. These two tasks were accomplished according to the proposed time line.

Arrangements were made with the heart catherization lab to participate in the inservice process. This department has a consistent pediatric patient census but it is not the primary population serviced by the staff. The supervisor and staff had also expressed interest in improving skills in working with pediatric patients. Weekly sessions were scheduled for Fridays as this is the normal day for scheduled pediatric procedures. This schedule would allow for immediate practical application of information received, review and discussion of the staff's interaction with current cases, and consistent clinical supervision. This schedule also adhered to new staffing policy by utilizing regular staff hours for inservice participation.

Prior to implementing the inservice system the investigator conducted an observational study of two procedures involving pediatric patients. The same team staff members were involved in both procedures. The investigator had no direct involvement or interaction with the staff or patients during the procedures. Behaviors of tactile and verbal interaction between the staff and the patients were noted on a checklist as they were exhibited. Observational time began when the patient entered the heart catherization lab and concluded when the procedure was completed. The ages of the children were thirteen months and two years. Another observational study was conducted at the end of the seven week inservice period. Again, two pediatric cases were observed. Team staff members consisted of all but one of the original team members observed in first study. Ages of the patient's were three

and four years old. The information collected was used to quantified changes in staff behavior and language usage in working with pediatric patients.

Five specific topics were chosen for inservice presentation with two open forums scheduled to address the department's particular needs and concerns. Topics included: (1) concerns of hospitalized children, (2) communication with children and families about health care experiences, (3) separation anxiety, (4) pain management, and (5) procedure preparation. Sessions were organized to last not more than forty-five minutes. Twenty minute oral presentation, 15 minute staff interaction activities (role-playing, demonstration, role-modeling), and 10 minute question-answer time.

Roadblocks to the planned implementation became apparent at the first scheduled session. One roadblock was the new staffing policy. It was not possible for a full complement of staff members to be present unless scheduled procedures demanded such. Staff members were not allowed to attend unless they were actually scheduled to work. This posed a problem for consistent attendance and distribution of information. Second, was the unpredictability of the number of emergency or complicated cases the staff had to handle. Such cases often involved back-to-back procedures for ten to twelve hours. This eliminated any possibility of the staff attending formal inservice sessions.

Administration of the pre-attitudinal survey was set for the first scheduled inservice date. Because of low case involvement

on that date a minimum staff complement was present. It was then arranged to distribute the survey to the entire staff and allow one week in which to complete and return the surveys.

An alternate plan was developed to provide the presentation material in a form that the staff could use in an independent study format. Detailed outlines were provided on the scheduled topics and placed in a notebook. Hand-out and reference materials were included, enough copies for each staff member. A check-off sheet was attached to the notebook for staff to initial indicating they had read the material. Two of the presentations were placed on tape for use by staff at their convenience. Information was provided to the department at the beginning of each week giving the staff several days to review the material before Friday when clinical supervision took place. During clinical supervision discussions focussed on the week's material and its application to working with the pediatric population. Interaction and discussion on the inservice material took the form of informal one-on-one or small group sessions.

This method allowed for adaptation to the department's specific needs, reduced the possibility of cancellation due to emergencies or case complications, allowed the staff adequate time to be familiar with the material, and provided opportunity for role-modeling and feedback during actual procedures.

At the end of the ninth week evaluation forms were distributed to staff members to rate the effectiveness of the inservice system. The data was collected and tabulated. During

the tenth week results (attitudinal survey, observational study, and evaluation forms) were shared and discussed with the staff.

Chapter 5

Results, Conclusions, and Recommendations

Results

A two part questionnaire was developed for use pre- and post- to inservice presentations to assess the staff's present comfort level and current practices in working with pediatric patients and any changes that may have occurred after inservice period (See Appendix D). Part one was designed to obtain staff's reporting of routine practices in working with pediatric patients in specific situations. Three scenarios were presented and staff members were requested to record how they would react to each situation. Responses were grouped by similarities. The assumption being that under certain situations staff members would follow basic policy and procedure for that department and thus reflect a pattern in their responses on the questionnaire.

In Part two, a five point rating scale was developed to measure staff comfort in working with pediatric patients. The scale reflected several issues concerning children including administration of medication, parental involvement, procedure preparation, and support of patients during procedures. The ratings ranged from one, indicating a high comfort factor, to four indicating a low comfort factor, five indicated situation did not apply to staff member. The average of these scores indicated staff over-all comfort level in working with pediatric patients.

Objective observations were conducted by the investigator as

a means to quantify other changes in staff behavior and language usage. A checklist was developed containing behaviors of tactile and verbal interaction between staff members and pediatric patients during the medical procedure (See Appendix E). The scores are directly correlated to the number of times the behaviors were exhibited.

The observational study of staff behaviors with children showed no significant change pre- or post- to inservice presentations (Table 2). Staff exhibited a consistent pattern of touching and stroking children in an reassuring manner. There was a slight increase in the number of verbal interactions. Verbal comfort level checks by staff of the child during preparation and procedure increased as did comments eliciting the child's cooperation. There may be three reasons for this increase, (1) the staff's increase awareness on the needs and concerns of pediatric patients, (2) the child's state of consciousness during the procedure, and (3) the difference in developmental level of the patients in the two studies.

Pre- and post- survey of current department practices in working with children addressed three issues, (1) providing procedure information to patient, (2) providing support for an emotionally upset child during procedure, and (3) patient's right to privacy. Investigator was looking for a pattern in the responses that would reflect the practices of the department. The responses varied in only one scenario from pre- to post- survey. Seven staff members completed the survey.

Table 2

Observational Study
Medical Staff Behaviors in Working with Pediatric Patients

Behavior	Number of Occurrences Pre-	Post-
Tactile:		
Stroking child	16	18
Patting child	5	4
Holding child	3	2
Touching child lightly	3	5
Verbal:		
Reassuring child	11	12
Checking child's comfort level	7	10
Giving Commands	0	0
Eliciting cooperation	5	9

On providing information to patients, all responses reflected elements of explaining the sights and sounds of the environment, providing information at the patient's level of understanding, and being honest in answering questions.

In providing support to a child who becomes upset during a procedure all staff members but one, in the pre-survey, responded first with "administer additional medication". Only one responded by suggesting using a calm and reassuring voice with the child. In the post-survey the use of medication was still a response but

it came second to offering verbal reassurance and/or attempting to elicit cooperation from the child. This shift in response may suggest a increase confidence and comfort level of the staff in their ability to cope with such situations.

The department's practice to insure a patient's privacy was consistent in both the pre- and post- survey. Each staff member recognized the need to have a member of the patient's same gender perform the preparation procedures involving private body areas, to close doors, and to keep private body areas covered as much as possible.

Results of the pre- and post- comfort level survey (Table 3) indicated an increase in staff comfort when offering emotional support to pediatric patients and also in providing explanations of procedures. Other variables did not change though there was movement of degrees among the staff in their recording of comfort level.

A five point evaluation questionnaire was developed to measure whether the method of inservice presentation addressed the professional growth and development needs of the staff in working with pediatric patients (See Appendix F). The questionnaire focussed on issues presented and format of presentation. A rating of five indicated a high assessment factor of the information and presentation, one indicated a low assessment factor of information and presentation. Final rating was the mean score of the total staff evaluations.

Table 4 shows the results of the evaluation concerning

content, presentation, and overall effectiveness of the inservice process. The written and clinical supervision components received high assessment ratings for meeting the staff's growth and development needs. Clinical supervision sessions were assessed higher than either written or oral presentations but only with a .09 higher rating than written. The oral component rated below the middle score of three, indicating the staff felt it was the least effective method of presentation. Two staff members wrote comments on their evaluations indicating the value of the clinical supervision was in "the immediate feedback of information" and the "hands-on guidance" in working with pediatric patients.

Table 3

Staff Comfort Level in Working with Pediatric Patients

Variable	Pre- (n=7)	Post- (n=7)
Using restraints	1.85	1.85
Parents present during medical procedures	3.57	3.54
Requesting medication:		
Pre-procedure	1.42	1.42
Supplement medication	1.71	1.71
Emotional support of patient	2.28	2.00
Providing explanations of procedures/routines/treatments	1.87	1.57

Table 4
Inservice Evaluation
Issues in Working with Pediatric Patients

Method of Presentation	Mean Score (n=11)
Written (Outlines/hand-outs)	4.36
Oral (Tapes)	2.90
Clinical supervision sessions	4.45
Overall effectiveness	4.45
Content of Presentation	
Needs and concerns of ill children.	4.18
Communication with children and families about health care experiences.	4.27
Separation anxiety.	3.81
Pain management.	4.09
Procedure preparation.	4.45

Discussion

Originally all inservices were to be formal oral presentations with written material and clinical supervision as follow-up methods. Because of difficulties encountered, oral presentations became unfeasible. Tape recordings were made of two of the presentation topics but accessible listening equipment was not

always available. This may be why the oral component received such a low rating. Space, time, and accessibility in the heart catherization lab was very limited.

Being a specialized department the heart catherization lab operated continually as long as there were procedures scheduled. It was done so with a very small staff. Rest breaks and lunch hours were not scheduled but fitted in when one staff member could relieve another from their duties. This may explain the preference of the written material. Staff members each had a copy of the material and could read it in part or wholly as their personal time allowed.

Clinical supervision was easily adapted into the activity flow of the department. There was continual interaction staff-with-staff and staff-with-patient. Opportunities to enhance those interactions could be accomplished in a positive manner without interfering in the routines of the medical procedure. Exchange of ideas and information was a natural and constant process for the department. Clinical supervision adapted well into this atmosphere to become an effective method of encouraging and enhancing staff skills.

The lack of significant change in attitudes and practices of the staff may have been influenced by their experience with the pediatric child life specialist. The child life specialist conducts a preparation and support program for children receiving medical procedures. Part of the program involves accompanying pediatric patients to the catherization lab and remaining with the

children throughout the procedure to provide emotional and informational support. The staff has been exposed to this supportive role model for approximately two years. Whereas the inservices have provided a more in-depth study of pediatric issues, certainly the continual presence of a role model has effected current behaviors and attitudes.

There was noticeable change in one particular staff member whose interaction with the children prior to inservices was total silence or diversional small talk. After materials were given on communication with children and families concerning health issues and hand-outs that suggested appropriate language to use with children, this staff member began to display supportive verbal behaviors with the children. Direction was also sought during clinical supervision on more appropriate ways to handle various situations involving young patients. Observation of the staff member during clinical supervision demonstrated a significant change in behavior when working with pediatric patient.

Conclusions

This practicum attempted to provide an effective method to increase the awareness of health care professionals to the needs and concerns of hospitalized children and their families. Through this systematic method the ability of the staff to deal with children during medical procedures would be enhanced and thus result in a greater personal comfort for the staff. The method of

inservice was shown to be considered effective by the participating staff in its written and clinical supervision components. Interaction with children during the medical procedure increased in the area of verbal reassurance and eliciting cooperation. Staff comfort level increased in the areas of providing children with emotional support and explanations of procedures and treatments. Though the sample was small and evolved in a short time frame, anecdotal feedback and observational study reinforce the belief that overall the method of inservice had an impact on the professional growth and development of the health care givers and enhanced their ability in dealing with hospitalized children.

Recommendations

1. Increase sample numbers in repeat of problem solving activity.
2. Develop further follow-up sessions for feedback from staff at regular intervals to address various issues and concerns that occur or need to be reviewed.
3. Develop additional video and/or tape recordings of presentation of pediatric issues for use in departments hospital wide.
4. Expand written material to provide a resource base for other departments in selecting pertinent topics for particular departments besides general pediatric issues.

5. Provide information concerning the problem solving activity to interested physicians, department directors, student nurse instructors, and other interested parties.

At this point it is not known whether this program will continue in the medical center site. The plan will be submitted to the education department for review, consideration and financial feasibility. Results of the practicum will also be shared with colleagues, from the author's field, who belong to a regional organization. Feedback will be sought concerning possible revisions, additions, and discussion of outcome.

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Appendix A

Survey of Health Care Employees

SURVEY OF HEALTH CARE EMPLOYEES
ISSUES IN WORKING WITH PEDIATRIC PATIENTS

Department:

_____

As a health care professional which areas of information would benefit you in working with pediatric patients: (check all that apply)

1._____needs and concerns of ill children.

2._____use of appropriate language/vocabulary/terminology with children.

3._____psycho-social issues of children and their families.

4._____coping styles of children.

5._____parental participation in the child's care/treatment.

6._____preparation of children for medical procedures. (psychological/emotional/behavioral)

7._____basic child development information.

8._____Bibliotherapy, use of books and stories with children.

9. Other_____

Have you attended any workshops, seminars, educational courses that related to working with children? If so, list title or subject matter:_____

_____

_____

_____

Please take a few moments to complete this brief survey. The information provided is important in developing inservices directly related to working with ill children and their families.

Place completed surveys in manila envelope to be returned to Pediatric Department.

Thank you for your time and input.

Appendix B

Tabulation Table of Survey of Health Care Employees

Tabulation of Survey of Health Care Employees
Issues in Working with Pediatric Patients

Identified Issues	Number of Responses	Percentage (n=46)
Preparation of children for medical procedures. (Psychological/emotional/behavioral)	34	73%
Needs and concerns of ill children.	32	69%
Use of appropriate language/vocabulary/ terminology wiht children.	30	60%
Parental participation in the child's care/treatment.	25	54%
Coping styles of children.	22	47%
Psycho-social issues of children and their families.	15	32%
Bibliotherapy, use of books and stories with children.	11	23%
Basic Child development information.	9	19%

Appendix C

Implementation Plan

Implementation Plan

Task: Gain agreement from one department in medical center to participate in implementation of practicum.

Steps: [1]. Contact department supervisor and secure agreement for staff's participation in practicum.

Responsible Individual: Author

Time Required: Agreement to be reached prior to implementation period.

Task: Develop survey to measure staff attitudes concerning working with pediatric patients.

Steps: [1]. Gather samples of attitudinal surveys.

[2]. Request assistance from director of medical center's education department and community resource person in developing appropriate tool.

[3]. Obtain sufficient number of final tool to use with staff..

Responsible Individual: Author will collect all samples and contact various individuals to assist in development and review of tool. Cost of duplication of tool will be minimal.

Time Required: First two weeks of implementation period.

Task: Develop observational tool.

Steps: [1]. Gather samples of various observation tools.

[2]. Select criteria for observational tool.

[3]. Review with education department director and community resource person as to suitability of criteria.

[4]. Finalize observational tool.

Responsible Individual: Author will gather all samples and contact individuals to assist in development and review of tool.

Time Required: First two weeks of implementation period.

Task: Develop materials for presentation to staff on issues concerning use of appropriate language and the needs and concerns of hospitalized children.

Steps: [1]. Gather resources and information to develop oral presentation to staff.

[2]. Determine length and number of presentations needed to disseminate information.

[3]. Select materials for hand-outs for staff to use as resource material.

[4]. Arrange presentation place, time, and dates.

Responsible Individual: Author will develop and prepare all materials for presentation and secure enough copies of hand-outs for department staff. Contact will also be made with department supervisor in arranging dates for presentations. Cost will be minimal.

Time Required: Pre-preparation will be done during first two

weeks of implementation period and then preparation for each session will be on an on-going basis throughout the implementation period, second through eighth week.

Task: Administer pre-attitudinal survey to staff.

Steps: [1]. Arrange place, time, and date for survey to be administered.

[2]. Distribute survey to staff to complete. Give brief explanation to purpose of survey.

[3]. Collect survey upon completion.

Responsible Individual: Author will contact department supervisor to arrange for administration of survey.

Time Required: By third week of implementation period.

Task: Conduct pre-observational study.

Steps: [1]. Arrange date(s) for observational study.

[2]. Conduct study.

Responsible Individual: Author will clear date(s) with supervisor. Staff will not be aware of reason for author's presence.

Time Required: BY third week of implementation period.

Task: Conduct inservice session with department staff on issues of use of appropriate language and needs and concerns of hospitalized children.

Step: [1]. Inservices will be a combination of oral

presentation, written material, and role-playing with staff. Inservices will be 30 to 45 minutes in length, four to six inservices will be conducted.

Responsible Individual: Author will conduct all inservices.

Time Required: Third through eighth week of implementation period.

Task: Administer post-attitudinal survey. Conduct post-observational study.

Steps: [1]. Arrange date and time to administer post-attitudinal survey.

[2]. Distribute survey to staff, collect data when completed.

[3]. Arrange for date(s) to conduct post-observational study.

Responsible Individual: Author will contact department supervisor to arrange post-survey date and time, and date(s) for post-observational study.

Time Required: Ninth week of implementation period.

Task: Follow-up of pre- and post-attitudinal survey and pre- and post-observational study.

Steps: [1]. Gathered data will be reviewed and analyzed.

[2]. Results will be shared with department supervisor and staff.

[3]. Concluding sessions will concentrate on clinical supervision, the department's specific issues in working with children, and evaluation.

[3]. Survey and observational tool will be reviewed for possible revisions or alterations for future use.

Responsible Individual: Author will review data. Assistance will be sought for review of tool through education department's director and community resource person. Author will make any changes, revisions of tools. Questionnaire will also be developed and distributed by author to staff to assess satisfaction of inservices to meet staff's professional growth and development needs. Information will be used to make any alteration in presentation format to better meet the needs of future participant's.

Time Required: Ninth and tenth week of implementation period.

Appendix D

Pre- and Post- Survey of

Employees Practices and Comfort Level

in Working with Pediatric Patients

St. Bernardine Medical Center
Employee Survey

I. How would you address the following situations:

A. An eleven year old child is hospitalized for a heart catherization. The child has not had a heart catherization before What information would you provide concerning the procedure?

B. A five year old child becomes very upset during the medical procedure in your department. The child is crying and moving about making it difficult to complete the procedure. How would you handle the situation?

C. What would you do to insure the privacy of a modest fourteen year old girl during a medical procedure in your department?

II. In working with pediatric patients, how comfortable are you in the following situations:

Using restraints on pediatric patients during medical procedure/treatment.

Very Comfortable	Somewhat Comfortable	Somewhat Uncomfortable	Very Uncomfortable	Does Not Apply
1	2	3	4	5

Parents present during medical procedure.

Very Comfortable	Somewhat Comfortable	Somewhat Uncomfortable	Very Uncomfortable	Does Not Apply
1	2	3	4	5

Requesting medication for pediatric patients during painful procedures/treatments.

Pre-procedure medication:

Very Comfortable	Somewhat Comfortable	Somewhat Uncomfortable	Very Uncomfortable	Does Not Apply
1	2	3	4	5

Supplemental medication:

Very Comfortable	Somewhat Comfortable	Somewhat Uncomfortable	Very Uncomfortable	Does Not Apply
1	2	3	4	5

Supporting the pediatric patient who is emotionally upset during procedures/routines/treatments.

Very Comfortable	Somewhat Comfortable	Somewhat Uncomfortable	Very Uncomfortable	Does Not Apply
1	2	3	4	5

Providing explanations of procedures/routines/treatments to pediatric patients.

Very Comfortable	Somewhat Comfortable	Somewhat Uncomfortable	Very Uncomfortable	Does Not Apply
1	2	3	4	5

Appendix E

Observational Study Checklist

Observational Study
Medical Staff Behaviors in Working with Pediatric Patients

Department:_____

Date:_____

Patient Information:_____

Behavior	# of Occurrances
Tactile:	
Stroking child	
Patting child	
Holding child	
Touching child lightly	
Verbal:	
Using child's name	
Reassuring patient--- Ex: "it's alright" "we're almost finish" "you're being such a help"	
Checking comfort level-- Ex: "how are you doing?" "does it hurt?" "where is it botnering you?"	
Giving commands--- Ex: "stop" "don't do that" "don't move" "sit/lay still"	
Eliciting cooperation--- Ex: "I/we need you to..." "now is the time...." "can you help us by..."	

Appendix F

Inservice Evaluation Form

Inservice Evaluation Form
Issues in Working with Pediatric Patients

On a scale of 1 to 5, 5 being the highest mark, 1 being the lowest mark, please evaluate how effective the inservices were in meeting your professional needs in understanding the issues of pediatric patients.

Method of Presentation:

A. Written material (Outlines and handouts)

5 4 3 2 1

B. Oral presentation (Tapes)

5 4 3 2 1

c. Clinical supervision sessions

5 4 3 2 1

Specific Topics:

A. Needs and concerns of ill children.

5 4 3 2 1

B. Communication with children and families about health care experiences.

5 4 3 2 1

C. Separation anxiety

5 4 3 2 1

D. Pain Management

5 4 3 2 1

E. Procedure preparation

5 4 3 2 1

Comments or suggestions:_____

_____

_____